TABLE OF CONTENTS

TABLE OF AUTHORITIES

Statutes and Regulations

Federal

Statutes and Regulations (con't)

District of Columbia

Page

Statutes and Regulations (con't)

Other

Miscellaneous

No. 91-1326

In The
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1991

DISTRICT OF COLUMBIA
AND SHARON PRATT KELLY, MAYOR,
Petitioners,

v.

THE GREATER WASHINGTON BOARD OF TRADE,
Respondent.

**On Writ of Certiorari to the
United States Court of Appeals
for the District of Columbia Circuit**

Brief of the District of Columbia Insurance Federation, the National Association of Independent Insurers, The Alliance of American Insurers, Liberty Mutual Insurance Company, PMA Group and Metropolitan Washington Association of Independent Insurance Agents as *Amici Curiae* Urging Affirmance of the Decision Below

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The issue in this case is whether the federal Employee Retirement Income Security Act ("ERISA") § 514(a), 29 U.S.C. § 1144(a), preempts an amendment to the District of Columbia workers' compensation legislation styled the

Equity Amendment Act ("the Act"). D.C. CODE § 36-307(a-1) (1990). The Act would impose a new health insurance obligation (a "welfare benefit" under ERISA § 3(1), 29 U.S.C. § 1002[1]), not on all District employers, but only on District employers who already provide health insurance to their employees, and only for employees who have elected to enroll in the health insurance plans offered by their employers.

INTEREST OF AMICI

The District of Columbia Insurance Federation is an association of insurance companies that write insurance in the District of Columbia. Its membership includes most of the insurers who provide workers' compensation insurance to District of Columbia employers. The Alliance of American Insurers and the National Association of Independent Insurers are national associations of insurance companies that write insurance, including workers' compensation insurance, in the District of Columbia. Liberty Mutual Insurance Company is the largest writer of workers' compensation insurance in the District and throughout the United States. PMA Group is a major regional workers' compensation insurer in the mid-Atlantic region, including the District. The Metropolitan Washington Association of Independent Insurance Agents is an association of agents who sell insurance policies, including workers' compensation insurance policies, in the District.

Collectively, *amici* represent the major portion of insurers writing workers' compensation insurance in the District and the agents selling such insurance. Although the Act directs employers to provide the new health insurance benefits, the burden of carrying out the Act's commands falls almost entirely on the workers' compensation insurance industry; by statute and regulation all obligations of employers under the workers' compensation statute must be secured by insurance unless the employer is self-insured. As we show below, the Act is essentially unworkable. It would place an intolerable burden on workers' compensation insurance carriers. They would find themselves obliged to provide health insurance benefits that many workers' compensation insurers have neither the experience nor the expertise to write and which in many circumstances cannot be written at all.

SUMMARY OF ARGUMENT

1.

The District of Columbia has attempted to impose a health insurance obligation on employers by calling it a workers' compensation benefit. No matter how the employer attempts to comply with the Act, the Act still would "relate" to ERISA-covered welfare benefit, health insurance plans. ERISA's preemption clause covers and voids this statute.

2.

Under District law most employers would have to comply with the obligation through their workers' compensation insurance. Because of the vast differences between health insurance and workers' compensation insurance, it would be impossible for any employer to obtain a separate insurance policy to cover this obligation, leaving amendment of ERISA-covered existing health insurance plans the only way to comply.

3.

The Act improperly tacks health insurance benefits onto

a workers' compensation statute. States universally provide for workers' compensation by law as a trade-off for relieving employers of tort liability. Health insurance is voluntary, governed by contract and often comes out of the tug and pull of collective bargaining. The two insurance systems and the insurance carriers that provide the coverage are too different to be linked in this way.

4.

Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983), does not save the Act from preemption.

a. *Shaw* held that a New York disability insurance statute that imposed disability benefits requirements for pregnancy on employers was not preempted by ERISA. Disability benefits plans are exempt from ERISA preemption. A disability insurance plan set up specifically to comply with the New York statute was within the exception for disability benefits. The Act is a workers' compensation statute that imposes health insurance plan obligations on employers. Health insurance is not exempt from ERISA preemption.

b. A health insurance plan set up to comply with the Act is still a health insurance plan and not within the exception for workers' compensation benefits. The Act thereby encroaches on an area of exclusively federal concern by going beyond the usual purpose and reach of workers' compensation. As the Court held in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525-26 (1981), ERISA preempts any state enactment that attempts to do this.

c. If the Act is not held preempted, the door is open to the states to impose all kinds of health and pension benefits

obligations on employers not only through workers' compensation legislation but also through unemployment compensation legislation, forcing changes in the terms of ERISA-covered plans. ERISA's preemption clause surely was intended to prevent this.

ARGUMENT

I. THE ACT RELATES TO ERISA PLANS, CONFLICTS WITH ERISA AND IS PREEMPTED.

A. The Act Refers Expressly to and Obviously "Relates to" ERISA Welfare Plans.

1. The Act Seems To Have Been Designed To Evade ERISA Preemption

The Act and its applicable regulations purport to fold ERISA-controlled health insurance benefits into ERISA-exempt workers' compensation plans. As written, the Act would

-- require employers who provide health insurance for their employees to provide "equivalent" health insurance coverage for participating employees who are injured on the job and become eligible for worker's compensation, including coverage for other family members where the employee has elected family coverage. D.C. CODE § 36-307(a-1)(1).

-- provide that such health insurance benefits are payable only when injured employees are "away from work" due to the work-related injury. *Id.* § (a-1)(2)(A).

-- require employers to continue such coverage for the duration of the injury and any recurrences, up to a maximum of 52 weeks. *Id.* § (a-1)(1), (3).

-- require employers to pay employees' normal contribution towards their coverage under the health insurance policy even if, as nearly all employer health plans provide, employees are obliged to pay a portion of the health insurance premium themselves. *Id.* § (a-1)(4).

-- appear to require employers to pay the normal deductible (ordinarily anywhere from $100 to $1,000) and co-payment (often 20%) that employees usually pay before the insurer's obligation kicks in. *Id.*

-- fix the health insurance benefits to be provided to injured workers' compensation-eligible employees as of the date of an injury, even if the employer or its health insurance carrier makes a change in the plan or policy provisions thereafter. *Id.* § (a-1)(1); 7 DCMR § 213.2 (pending).

-- do not impose any equivalent burden on employers who provide self- funded health care reimbursement plans, for example by direct payment to health maintenance organizations.

-- impose the duties of paying injured employees' premium shares and providing the health insurance benefits (i.e. paying the provider or reimbursing employees for payments to providers for treatment of employees and their families) on employers' workers' compensation insurance carriers; except for the very few self-insured employers, all workers' compensation benefits in the District of Columbia must be paid for and provided by insurance, D.C. CODE § 36-334, and the workers' compensation insurance carriers are expressly made responsible for providing the Act's health insurance benefits, 7 DCMR § 214.5, 7 DCMR § 213.7 (pending).

-- provide no such health insurance benefits for employees injured on the job whose employers do not offer health insurance as a fringe benefit or who have declined employer-offered health insurance.

In summary, the Act requires employers who have ERISA § 3(1) health insurance plans either to change their plans to conform with the Act or, theoretically, to maintain separate health insurance plans for workers who are injured on the job. By the Act the District seeks to evade ERISA preemption and substitute state for federal ERISA regulation of employers' ERISA-covered health insurance plans.

2. The Act Is Inextricably Tied To ERISA-Covered Plans

On its face the Act's requirement that employers provide health insurance coverage to injured workers is couched as a workers' compensation benefit. But the Act does not require all employers to provide health insurance benefits for all workers' compensation eligible employees. *Greater Washington Board of Trade v. District of Columbia*, 948 F.2d 1317, 1323, 1324 text at n. 21 (D.C. Cir. 1991) ("*GWBT*"). It reaches only those employers who have health insurance plans already in place. Its benefits reach only those employees who already participate in their employers' plans. Its mechanism is for the new workers' compensation health benefit to duplicate whatever benefit the plan happens to provide as of the date the worker is injured. It does not cover employers who provide health benefits to their employees by means other than insurance. In the simplest terms announced by this Court, the Act "refers to -- indeed solely applies to -- ERISA employee benefit plans," is a "state law which singles out ERISA plans, by express reference, for special treatment," and it

therefore "is preempted." *Mackey v. Lanier Collections Agency*, 486 U.S. 825, 829, 838 n. 12 (1988).

Both the Second Circuit and the D.C. Circuit agree that the virtually identical Connecticut and District of Columbia statutes "relate" to employee benefit plans within the meaning of ERISA § 514(a). *R. R. Donnelley & Sons, Inc. v. Prevost*, 915 F.2d 787, 791-92 (2nd Cir. 1990), *cert. denied*, ___ U.S. ___, 111 S.Ct. 1415, 113 L.Ed.2d 468 (1991) ("*Donnelley*"); *GWBT*, 948 F.2d at 1322. *Donnelley* held that the Connecticut statute survived preemption because it permitted employers to provide the required health insurance benefits by setting up a separate health insurance plan for injured employees. The Second Circuit considered that this would be a plan established "solely for the purpose of complying with applicable workmen's compensation laws," excluded from ERISA coverage altogether by § 4(b)(3), 29 U.S.C. § 1003(b)(3). 915 F.2d at 793. *GWBT* held that the Act was preempted despite § 4(b)(3), because (1) even a separate plan would tie "the new benefits to existing benefits," 948 F.2d at 1324, (2) the requirements of the Act burdened only "employers already providing benefits through ERISA plans," *id.*, and (3) it would undermine "the broad purposes of ERISA preemption," *id.* at 1325.

Those purposes include protecting ERISA plans from a "patchwork scheme of regulation" by different states, which might discourage employers from adopting or maintaining ERISA plans. *Id.*, quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). To serve those purposes the Court has construed ERISA preemption broadly and has construed exceptions from preemption narrowly. The Court reaffirmed § 514(a)'s "broad preemptive purpose" just a month ago. *Morales v. TWA*, No. 90-1604, 60 U.S.L.W. 4444, 4446 (U.S. S.Ct., June 1, 1992), quoting and citing this Court's ERISA preemption cases: *Ingersoll-Rand Co. v. McClendon*, 498 U.S. ___ (1990); *FMC Corp. v. Holliday*, 498 U.S. ___ (1990); *Pilot Life Ins. Co. v. Devereaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). *See also Gade v. National Solid Wastes Management Ass'n*, No. 90-1676, 60 U.S.L.W. 4587, 4591-97 (plurality opinion), 4593 (concurring opinion) (U.S. S.Ct., June 18, 1992).[1]

B. Whether an Employer Amends an Existing Health Benefits Plan or Sets Up a New Separate Plan to Comply With the Act, the Act Will "Relate To" an ERISA Welfare Plan.

If the employer complied with the Act by amending its existing health insurance plan, the Act not only would "relate to" but would force a change in an ERISA-covered plan. The alternative is for employers to set up separate health insurance plans with benefits "equivalent" to the covered plan's benefits (but with a 52 week limit and 100% employer-paid premiums, deductibles and co-payments). *GWBT*, 948 F.2d at 1325. The D.C. Circuit pointed out that even this would "have a serious impact on

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[1] *Gade* indicates that if there were any doubt about express preemption here ERISA would nonetheless impliedly preempt the Act. It "sufficiently interferes with federal regulation" of welfare benefit plans "to be deemed preempted, because it "directly, substantially, and specifically regulates" health insurance plans. 60 U.S.L.W. at 4592 (plurality opinion).

the administration and context of the ERISA-covered plan." *Id.* Any employer contemplating a change in the ERISA-covered plan would have to consider the equivalent change in the workers' compensation health insurance plan and, as we also noted (p. 8 *supra*) this could persuade employers that health insurance plans were more bothersome than beneficial. *Id.* Such a result is surely contrary to Congress' intentions, especially in a time when greater, not lesser, access to health insurance is a national imperative.

Of course any such new, separate health insurance plan would itself be an ERISA-covered "welfare benefit plan" under ERISA § 3(1), 29 U.S.C. § 1002(1), providing medical, etc. benefits in the event of accident. So however employers decided to meet the Act's demands, the Act would "relate" to ERISA- covered plans by tying the workers' compensation mandated health insurance to the benefits stated in the existing ERISA-covered plan and by requiring employers either to amend their existing ERISA-covered plans or set up new ERISA-covered plans.

No insurance company will sell and no employer will be able to purchase such a separate workers' compensation-limited health insurance plan.

II. NO SEPARATE HEALTH INSURANCE PLAN EXCLUSIVELY FOR WORKERS' COMPENSATION RECIPIENTS IS FEASIBLE

Petitioner, its supporting amici and the Second Circuit all ignore a stubborn fact. In the real world of workers' compensation, which in the District of Columbia most employers must provide by insurance, the notion of separate health insurance plans exclusively for injured

workers, "maintained solely" to comply with the Act, purportedly a workers' compensation law, is pure fiction.

A. A Typical Example Shows the Problems the Act Would Create

Let us consider Mary Smith. Ms. Smith, employed in the District of Columbia, develops "carpal tunnel syndrome," a painful inflammation of the wrists, from the repetitive motions of her job. It is typical with this common work-related condition that Ms. Smith is better on some days than on others. She may be out of work for several days or several weeks at a time, returning to work whenever her condition permits. She applies for and receives workers' compensation for the wages lost during the days she does not report for work and for her medical expenses.

Ms. Smith has health insurance as a member of a group insured through her employer. Ms. Smith has family coverage of her husband and two minor children. The plan happens to include dental coverage. The cost of the plan is $450 a month; Ms. Smith pays $100 for her own coverage and $100 for her family's coverage. Her employer pays the other $250, or 55.56% of the total.

Ms. Smith is initially out of work for seven days. For those seven days, under the Act her employer would be obligated to pay 100% of her health insurance premium. So during that month of 21 working days, the employer would pay the full premium, $150, for the seven days, plus $144.44 for the rest of the month. Ms. Smith would pay $166.67. Every time Ms. Smith loses a day of work the employer would make a similar calculation and every time the employer would submit a claim for the additional premium to its workers' compensation insurance carrier.

Then (as they always do) health insurance premiums go up. To keep its costs from rising, the employer drops the dental benefits. Ms. Smith's children need dental work. Since Ms. Smith had dental benefits on the day she first "became eligible for workers' compensation benefits," the Act requires her employer somehow to provide a dental benefits insurance plan for the Smith children -- but only during those days when Ms. Smith is unable to come to work because her wrist hurts too much. Where is the employer to find a health insurance plan that provides dental benefits for only one of its employees (and her family) and then only on those days when she is away from work?

Ms. Smith's carpal tunnel injury does not get better. She cuts her work back to half time. Now Ms. Smith is "away from work" half of every day. The employer's workers' compensation insurance policy pays two thirds[2] of her lost wages for the half day she does not work. Does the Act require payment of half of her share of the premium for health insurance? It is common for employer group health plans to cover only employees who work more than half time. The Act would seem to require Ms. Smith's employer to find a separate plan to cover her and her family for half of each day.

Ms. Smith goes to a new job where no health insurance is provided at all, or where the health insurance plan excludes pre-existing conditions. Whenever Ms. Smith's carpal tunnel syndrome recurs and she is unable to go to work, her former employer's workers' compensation

[2]*See* the discussion of the workings of workers' compensation at IIIA, pp. 15-17 *infra*.

insurance policy pays her two thirds of her wages lost for those days. The Act requires the former employer, through its workers' compensation insurance carrier, to provide her and her family with her old health insurance coverage for those days until 52 weeks are exhausted.[3]

Ms. Smith's former employer goes out of business and its group insurance health plan lapses -- except for Ms. Smith, since workers' compensation insurance coverage (that under the Act now includes health insurance) continues as long as the worker remains disabled by the work-related injury. The employer's workers' compensation insurance carrier becomes a health insurance carrier by force.

The workers' compensation insurer must calculate the prospective, combined long-term risks of loss under the Act taking all of these imponderables into account. It must charge a premium to the employer that reflects that risk. For the workers' compensation insurance industry the Act would create a nightmare.

B. No Workers' Compensation Insurance Carrier Could Write a Separate Health Insurance Policy To Fulfill the Act's Requirements

Mary Smith's case, repeated many times but with virtually infinite variations, demonstrates why in the real world there is no possible separate plan alternative available even arguably to save the Act from interfering with ERISA-covered welfare benefit plans or save it from

[3]Or for the rest of Ms. Smith's working life if she happened to work in Connecticut instead of the District of Columbia. The Connecticut statute does not limit coverage to 52 weeks.

preemption. The only kind of separate plan that would satisfy it is a separate health insurance policy covering an unknown and unknowable number of Mary Smiths, with unknown and unknowable health conditions, and for unknown periods of time up to a potential total of 52 weeks that could be interpreted to stretch intermittently over entire working lives. Under the Act that policy would have to be procured or written by workers' compensation insurance carriers that are casualty, not life or health companies, that ordinarily are not licensed to write or sell health insurance, that may have no experience in calculating the risks involved in health insurance to set premium rates and whose premium rates would have to be approved by regulators.

No workers' compensation insurance carrier presently writes such a policy or is likely to be able to do so. Employers would be able to satisfy the Act only in one way. They would have to amend their existing health insurance plans and claim reimbursement from their workers' compensation insurance carriers for the additional costs. In turn, the workers' compensation carriers would then satisfy their statutory duties by reimbursing employers for the premium share of injured employees who are participants in the plan, the additional premium for family coverage of such injured employees with family coverage and the deductible and co-payment obligations of injured employees in the event of non-work-related illness or injury during the period of work-injury-related disability (up to 52 weeks).

There can be no doubt that Congress' ERISA preemption provision was designed to prevent such results of state meddling with ERISA-covered plans.

III. THE ACT'S INTRUSION INTO THE HEALTH INSURANCE AREA GOES WELL BEYOND THE PURPOSE, REACH AND MECHANICS OF WORKERS' COMPENSATION

A. Workers' Compensation Is Mandatory, Narrowly Limited and Enforced By an Elaborate System of Administrative Law

The District's workers' compensation statute is a typical, comprehensive procedural and substantive scheme for accomplishing a specific, narrow purpose -- payments for all work-related injuries -- in a speedy, efficient way. It covers work-related injury to or death of all employees working in the District of Columbia for all employers except the United States and District of Columbia government and the United States Congress. D.C. CODE §§ 36-301(9), (10), (12), 36-303(a). Compliance is mandatory. Employers' liability attaches regardless of fault, § 36-303(b). Employers are absolved from any other liability to anyone and employees' right to workers' compensation is exclusive of other remedies, § 36-304(a), (b). That is, the workers' compensation remedy replaces any tort remedy.

Compensation payable for permanent total disability as income replacement is limited to two thirds of an employee's average weekly wage, §§ 36-308, 36-311. It is further limited to the overall average weekly wage in the District of Columbia or $396.78, whichever is greater, § 36-305. The base for the two thirds figure is the employee's "wage loss," i.e. it is reduced by the amount he is able to earn despite the disability, § 36-308. The average weekly wage includes the value of board and lodging, but no other fringe benefits like health insurance.

(A few states do include the value of health insurance premiums in the wage base.)

Weekly payments for total disability continue as long as the disability continues. Partial permanent disability is compensated according to a schedule specifying a certain number of weeks of compensation for the loss, e.g., of an arm (312 weeks), eye (160 weeks), hearing in both ears (200 weeks), etc. § 36-308.

Compensation also includes 100% of employees' medical expenses resulting from the injury, including rehabilitation services. § 36-307(a). There are no deductibles or co-payments. In the case of death the employee's relicts receive up to $5,000 for funeral expenses; his widow or her widower receive 50% of the deceased's average wages; surviving children divide another 16 2/3%, raised to 50% upon the death or remarriage of the widow or widower. § 36-309. Employers must report all worker injuries to District authorities and keep a record of them, §§ 36-332, 36-331. They must post notices regarding workers' compensation rights and coverage.

An employer may challenge an employee's claim for workers' compensation on the ground, *inter alia*, that the injury was not work related. §§ 36-303(d), 36-320, 36-322. If one does, a full evidentiary hearing is held and the decision is appealable to the District of Columbia Court of Appeals, §§ 36-322, 36-329. If the employee then prevails he is entitled to payment of his attorney's fees by the employer. § 36-330.

Employers are required to "secure" payment of workers' compensation benefits by insurance issued by an approved insurance carrier. §§ 36-334, 36-336, 36-338. Premium rates are regulated. §§ 35-1514(2)(A), 35-1702(3). Policy

provisions are clear and simple; they cover whatever the applicable workers' compensation law requires. Employers may apply for and obtain permission to self-insure. § 36-334. Only a few very large employers do so.

All carriers and self-insured employers contribute to a special "second injury" fund that is used primarily to pay compensation for recurrence of an injury. § 36-340. The Act uses the special fund as the means for payment of the new health insurance benefits. Carriers and self-insured employers would pay into the fund and be reimbursed from the fund for the costs of the new benefits. D.C. CODE § 36-307(a-1)(5); 7 DCMR § 213.4 (pending).

B. Health Insurance Is Voluntary, Complex, Has Many Variations and Is Governed By Contract, Not Administrative Enforcement

None of these administrative, procedural and substantive requirements apply to employer-provided health insurance. No state does, nor consistently with ERISA may, require employers to provide health insurance.[4] By Congress' design in ERISA, non-unionized employers are free to design plans that make economic sense for them, while unionized employers are free to negotiate such plans with the employees' unions as their relative bargaining strength

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[4]Except Hawaii, by Congress' express but limited exemption of the Hawaii Prepaid Health Care Act from § 514(a) of ERISA. P.L. 97-473, § 301(a), 96 Stat. 2611, 97th Cong., 2nd Sess. (1983), codified as 29 U.S.C. § 1144(b)(5). The exemption was enacted to reverse *Standard Oil Co. of California v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981), in which the Hawaii Act was held preempted by ERISA and void. *See* 1982 U.S. Code Cong. & Admin. News 4595.

permits and the economic mix of wages and benefits commend to them. Some plans offer a choice (a "cafeteria") of benefits for employees to choose from. Many plans provide optional coverage for the employee's family.

By Congress' design in ERISA's preemption clause, states may neither interfere with, mandate changes in nor regulate such employer welfare plans, save as they may regulate the business of insurance, *see*, *e.g.*, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).[5] Employer welfare benefit plans need not file reports about employee claims with state authorities. Instead they must file elaborate reports with the Secretary of Labor, *see* 29 C.F.R. §§ 2520.101-1 *et seq*. No administrative agency adjudicates disputes over the validity of a health insurance claim or over the amount to be paid to a provider.

Employers and their plans are under no legal obligation to provide 100% or any percentage of medical expenses for a covered illness or non-work-related injury. Employers and their plans may require employees to pay any percentage of the premium cost for themselves and for their families. Plans normally require employees to pay a flat

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[5]The District has enacted several provisions regulating the health insurance industry. Statutes prescribe coverage for Medicare supplement policies, D.C. CODE §§ 35-2201 *et seq.*, require coverage for newborn infants, drug abuse, alcohol abuse and mental illness in all health insurance policies, §§ 35-1101 *et seq.*, 35-2601 *et seq.*, restrict health insurers' ability to exclude coverage of HIV infections or AIDS, §§ 35-221 *et seq.*, require approval of the coverage and premium rates of and prescribe that certain provisions be included in all individual (i.e. non-ERISA-covered) health insurance and accidental injury policies, §§ 35-517, 35-1532, require coverage for treatment by psychologists and optometrists, § 35-530, and regulate credit health insurance, §§ 35-1001 *et seq.*

deductible amount and co-pay a percentage (typically 20%) of medical expenses incurred up to some maximum. Employees are free to decline coverage for themselves (if, for example, a spouse's plan is cheaper or has better coverage) or for their families, keeping the premium contribution they otherwise would have to pay.

Health insurance policies contain elaborate provisions regarding, for example, coverage of pre-existing conditions and "experimental" treatment, and respecting "participating" vs. non-participating providers, upper limits of liability, restrictions on reimbursable hospital accommodations, and so forth. Benefits and premiums vary widely.

By loading a health insurance benefit onto a workers' compensation law, the Act strays too far from the generally understood definition, scope, purpose and mechanics of workers' compensation to be considered a "workers' compensation law" under ERISA § 4(b)(3). Most important, by limiting its reach to employees who already participate in employer-paid health insurance, the Act does violence to a cardinal principle that has informed workers' compensation statutes since the first one enacted in 1910: that they protect all employees of all covered employers.

C. The Act Creates An Unworkable Scheme

By definition, the Act applies only to employers who already provide medical benefits to their employees through health insurance policies. Those insurance policy plans would continue to be covered by ERISA and federal regulation. They would continue to be administered by experienced health insurance carriers. They would continue to provide specified benefits that may change by contract between employers and carriers. Such plans feature employee-paid premium contributions, deductions

and co-payments and cover illnesses and injuries of all participating employees and their families (if family coverage has been elected) at all times.

Any plan amended or created to comply with the Act would create, in the guise of a workers' compensation benefit, a special, constantly changing class of health insurance beneficiaries with benefits and premium obligations governed by District of Columbia law and regulation and not by contract, ERISA and federal regulation. The members of this class would be absolved from premium contributions (and perhaps from deductibles or co-payments). They would receive benefits that do not change as they do for all other covered employees if the contract changes. Their benefits would be fixed as of the date of injury, but only for the time that they were away from work and only up to a maximum of 52 weeks. As soon as they return to work their benefits revert to the provisions of the employer's general health insurance plan, which may have changed since the injury. The Act's lack of a contrary provision indicates that the 52 week period may be a "bankable," as opposed to a calendar, 52 weeks; i.e. the benefits may be available during recurrences of the injury however separated in time until the 52 weeks are used up, even if that is many years.

The separate class of employees would number between none and many at any particular time. It would change constantly, including only those employees who were injured on the job and are away from work, but not even all of them; the Act's benefits cover only injured employees whose employers provide medical benefits through insurance, and who already participate in the employer's insurance plan.

Workers' compensation insurance carriers would have to provide these benefits. Workers' compensation insurance carriers are classified as "casualty" insurers, regulated under Chapter 15 of D.C. CODE Title 35. Health insurers are classified as "life and health" insurers and are regulated under Chapter 5 of D.C. CODE Title 35. Workers' compensation insurers often have no experience in health care claims evaluation, health care costs, health benefits administration or the increasingly complex federal- private cost limitation and reimbursement system.[6] They nevertheless may well become subject to a whole range of ERISA reporting obligations respecting their performance of the Act's health insurance requirements. *See* ERISA § 103, 29 U.S.C. § 1023; 29 C.F.R. § 2520.101-1 *et seq.*; *Schulist v. Blue Cross of Iowa*, 717 F.2d 1127, 1132-33 (7th Cir. 1983).

To sum up: the problem the Act creates for the workers' compensation insurance industry arises directly from the difficulty of attempting to force one kind of insurance -- health insurance -- into a totally different kind of insurance scheme, namely workers' compensation.

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[6]*See, e.g.*, the new federal Health Care Financing Administration ("HCFA") regulations which mandate specific allowable physician, hospital, therapist and other health care provider fees for over 10,000 different medical services. 42 C.F.R. Parts 405, 413, 415, 56 Fed. Reg. 59501 *et seq. (1991)*, "Medicare Program; Fee Schedule for Physicians' Services, Fee Schedule Update for Calendar Year 1992 and Physician Performance Standard Rates of Increase for Federal FY 1992; Final Rules and Notice."

IV. THE PRINCIPLE OF *SHAW V. DELTA AIRLINES* DOES NOT SAVE THE ACT FROM PREEMPTION

A. In *Shaw* New York Tied ERISA-Exempt Disability Benefits to a Disability Benefits Statute. Here the District of Columbia Hangs ERISA-Covered Health Insurance Benefits Onto a Workers' Compensation Statute.

Petitioner, its allied *amici* and the Second Circuit all have ignored a crucial and dispositive difference between the disability insurance law that *Shaw* approved and a health insurance law that is labeled "workers' compensation" like the Connecticut statute approved in *Donnelley* and the Act at issue here.

The *Shaw* statute required employers to extend disability insurance to pregnant women. State-mandated disability insurance is a plan expressly exempted from ERISA § 4(a) coverage by § 4(b). The statute's impingement on ERISA-covered plans was accidental. It arose only from the circumstance that many employers included disability benefits in multibenefit welfare plans that included other benefits such as health insurance. *Shaw*, 463 U.S. at 92, 106-07. What saved the New York statute was the hypothesis that employers could satisfy it by setting up a separate pregnancy-disability plan. That would be a plan set up "solely" to comply with a state disability insurance law, exempt from ERISA under § 4(b)(3). It would be an employer disability income plan set up to comply with a disability insurance statute: apples and apples.

The Connecticut and D.C. statutes are not apple-apple statutes like the *Shaw* statute. Accepting (as the Second

Circuit and D.C. Circuit did) the applicability of the *Shaw* hypothesis of a separate health insurance plan for injured, workers' compensation eligible employees, the Connecticut and D.C. statutes are apple-orange statutes. That is, they would have employers -- but only employers who already have ERISA-covered health insurance plans in place -- set up a *health insurance* plan to comply with *workers' compensation* laws.

The impingement of these statutes on ERISA-covered plans is not accidental as it is with the Shaw statute. Rather it is the essence of the Connecticut and D.C. statutes. Their reach is both defined by and confined to ERISA-covered welfare plans and the employers who have them. Their purpose and effect is to impose new, non-contractual burdens on employers who offer ERISA-covered welfare benefits, which by definition are voluntary.

B. *Alessi* Precludes Approval of the Act

This Court already has rejected a similar state effort to encroach on an ERISA-protected preserve via a purported workers' compensation law. In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 521-26, the Court struck down New Jersey legislation that forbade employers to offset workers' compensation payments against retirement pension benefits. ERISA preempted and voided the statute, because it "related" to ERISA-covered pension plans and was an impermissible intrusion into an ERISA governed area.

The Court held that ERISA preempted "even indirect state action bearing on private pensions" because it "may encroach upon the area of exclusive federal concern.... ERISA's authors clearly meant to exclude the States from

avoiding through form the substance of the preemption provision." 451 U.S. at 525. The holding applies equally to ERISA welfare benefit plans, equally protected from state encroachment by ERISA preemption.

Alessi also resolves the confusion about preemption and exemption from preemption that infects petitioner's and its allies' briefs. "The only relevant state laws, or portions thereof, that survive ... preemption ... are those relating to plans that are themselves exempted from ERISA's scope." 451 U.S. at 523 n. 20. On the other hand, the ERISA exemption "for plans maintained *solely* for compliance with state workers' compensation laws -- has no bearing on ... plans ... which more broadly serve employee needs...." *Id.* (emphasis is the Court's).

Here the Act is a "portion" of a workers' compensation law that undeniably affects "plans which more broadly serve employee needs," to wit, by requiring either amendment of employers' existing medical benefit health insurance plans or by requiring establishment of new ones. Health insurance "more broadly serves employee needs" than the kind of benefits workers' compensation laws provide. The "need" it serves, comprehensive health protection for the whole family, is not a need traditionally served by the workers' compensation legislation that Congress had in mind when it exempted workers' compensation from ERISA coverage. *See* pp. 15-17 *supra*.

The Act impermissibly encroaches on an "area of exclusive federal concern." Moreover, its approval would open the door to far greater encroachments.

C. The Principle Behind the District's Position Reaches Too Far

The potential reach of the principle behind petitioner's position is vast. If this amendment to a workers' compensation law may lawfully expand ERISA health insurance benefits, another amendment to a workers' compensation law could expand pension benefits. It could, for example, require employers to begin paying pension benefits to injured employees for the duration of their injuries (as in Connecticut) or for 52 weeks (as in D.C.). It could require these payments whether employees are vested or not and whether they have reached retirement age or not. Alternatively such an amendment could require employers to continue contributing to injured employees' pensions even if the plan provided otherwise.

The principle would allow imaginative state legislators to load similar provisions onto unemployment compensation laws, also exempt from ERISA under § 4(b)(3). If petitioner's argument is accepted, state legislatures could require employers indefinitely to continue health insurance, to contribute to pensions or to pay pension benefits for fired or laid-off employees, no matter what their ERISA plans provided.

The principle also could work the other way. Petitioner's and its allies' position would permit state legislatures to enact workers' compensation amendments that absolved employers from paying any health insurance benefits to injured employees beyond paying for treatment for the injury even though the bargained-for ERISA welfare plan required their continuation. It would permit workers' compensation amendments that allowed employers to stop contributing towards the injured employee's pension

even though the bargained-for plan required such contributions to continue.

In sum, the kinds of welfare and pension benefits that employers provide to employees would not depend on collective bargaining agreements protected since the Wagner Act[7] by federal regulation nor would they be subject only to the commands of ERISA and its regulations. Instead they would be subject to the political winds blowing from whichever side, labor or management, had more political influence from state to state. Congress surely never intended such chaos.

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[7]The Court noted in *Alessi*:

> Where, as here, the pension plans emerge from collective bargaining, the additional federal interest in precluding state interference with labor-management negotiations calls for preemption of state efforts to regulate pension terms.

451 U.S. at 525.

CONCLUSION

The decision of the U.S. Court of Appeals for the District of Columbia Circuit should be affirmed.

Respectfully submitted,

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